Insurance and Benefits Follow – Up Audit No. A2012-01

Issued by the
Internal Audit Office
December 20, 2011

EXECUTIVE SUMMARY

The Internal Audit Office has concluded its fieldwork of the Follow-Up Audit of the OMB – Insurance and Benefits Audit Report dated September 2, 2009. Based on the Follow-Up Audit fieldwork, we have determined the status of pending recommendations for each audit finding as outlined in the table below:

Finding No.	Description of Findings	Status
1	The Administrative Services Agreement and the Business Associate Contract between the City of El Paso and Aetna have not been finalized.	Implemented
2	A full and fair review of second level medical appeals is not being conducted to make a decision about the appeal in question.	Implemented
3	The OMB Insurance & Benefits Policies and Procedures in place are a work in progress and have not been finalized.	Implemented
4	"Invoiced" retirees with United Concordia Dental Coverage are not being included in the data uploads.	Implemented
5	Vendor invoices are not being adequately reviewed before payment.	In Progress – Management Will Assume The Risk
6	The Health Fund and Workers' Compensation Cash Flow Analysis Reports prepared internally by OMB Insurance & Benefits require revisions.	Implemented

Based on the results of this Follow-Up Audit, we have determined that (5) five of the six original findings have been implemented, and (1) one is still in progress of being fully implemented.

For a detailed explanation of the findings and current observations please refer to the appropriate finding contained in the body of this Audit Report.

BACKGROUND

The *Generally Accepted Government Auditing Standards*, *Standard* 4.09 and 6.09, and the *International Standards for the Professional Practice of Internal Auditing, Standard 2500.A1,* require a post audit follow-up on all audit recommendations made in order to ascertain that appropriate corrective action is taken to address reported audit findings. The Internal Audit Office has conducted a Follow-Up Audit of the OMB – Insurance and Benefits Audit dated September 2, 2009.

AUDIT OBJECTIVES

The audit objective was to determine the status of the recommendations detailed in the original audit report dated September 2, 2009, which contained six (6) findings.

AUDIT SCOPE

The Follow-Up Audit was limited to a review of the six (6) findings and recommendations detailed in the "*OMB – Insurance and Benefits Audit"* dated September 2, 2009. The audit period covered in this Follow-Up Audit is the operations of the Insurance and Benefits Division during Fiscal Year 2011.

AUDIT METHODOLOGY

To achieve our audit objectives we:

- Conducted a review of the Insurance and Benefits internal Policies and Procedures,
- Conducted a review of Contract # 2007-097R – Aetna Life Insurance,
- Conducted interviews of Insurance and Benefits management and staff, and
- Conducted a review of Aetna and Medco invoices, 2nd Level Appeals, and Insurance and Benefits Cash Flow Analysis.

We conducted this performance audit in accordance with *Generally Accepted Government Auditing Standards*. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

This audit was also conducted in conformance with the *International Standards for the Professional Practice of Internal Auditing* by the Institute of Internal Auditors.

ORIGINAL FINDINGS, ORIGINAL RECOMMENDATIONS, MANAGEMENT'S RESPONSE TO ORIGINAL FINDINGS, CURRENT OBSERVATION, AND STATUS

Based on the results of follow-up test work, each original finding recommendation will be designated with one of the following four status categories:

Implemented	The finding has been addressed by implementing the original corrective action or an alternative corrective action.
In Progress	The corrective action has been initiated but is not complete.
Not Applicable	The recommendation is no longer applicable due to changes in procedures or changes in technology.
Not Implemented	The recommendation was ignored, there were changes in staffing levels, or management has decided to assume the risk.

Original Finding 1

Aetna Administrative Services Agreement

The Administrative Services Agreement between the City of El Paso and Aetna is still being reviewed by the City Attorney's office and not been finalized, therefore the City of El Paso and Aetna are operating under a Letter of Understanding (LOU).

Recommendation

The Aetna Administrative Services Agreement should be finalized.

Management's Response

Insurance & Benefits personnel have been working with the City Attorney's Office to finalize the Aetna Administrative Services Contract. Three conference calls between Aetna and City of El Paso were held in 2009. The City Attorney's Office has stated to Insurance & Benefits personnel and Aetna personnel that in the absence of a signed Administrative Services Contract, the proposal submitted by Aetna serves as a contract. The Annual Letters of Understanding between the City and Aetna reiterate the terms of the proposal. The City Attorney's office has committed to assist in completing the agreement within six months.

Responsible Party

Bertha Ontiveros – Assistant City Attorney and Irene Morales – OMB Insurance & Benefits Risk Manager

Implementation Date

February 1, 2010

Current Observation

The Administrative Services Agreement has been finalized.

Status

Implemented

Original Finding 2

Level 2 Appeals

A full and fair review of second level appeals, involving medical judgment, is not being conducted to make a decision about the appeal in question. The City of El Paso is:

- Upholding the decision made by the Third Party Administrator (TPA) in its appeal determination,
- Not consulting with an appropriately qualified health care professional in its review of denied claims involving medical judgments in accordance with the Employee Retirement Income Security Act of 1974 (ERISA) Rules and Regulations.

As of 7/6/2009, a total of three second level appeals were submitted to the City of El Paso for review by Aetna for fiscal year 2008/2009.

- One of the appeals was for determination as to the medical necessity of a cosmetic procedure to correct a disfigurement. The City of El Paso, upheld Aetna's decision to deny the appeal without evidence of any additional review or consultation with a health professional.
- Two appeals were administrative appeals; one contesting a network deficiency and the other the payment of a well child exam for a child over the age of seven. Both appeals were approved on a "one-time" basis by the City of El Paso.

Recommendation

OMB Insurance & Benefits should ensure that second level appeal reviewers provide a fair review of appeal documentation without regard to initial determination and by consulting with an appropriately qualified health care professional in its review.

Management's Response

The City of El Paso Health Benefit Plan is a self-insured governmental plan and is not required to comply with the Employee's Retirement Income Security Act of 1974 (ERISA). There are two types of appeals – administrative and medical. The administrative appeals are usually for time sensitive filing of medical bills by medical providers and/or members. Administrative appeals will continue to be handled by the designated City staff. Medical appeals are usually for medical procedures that do not follow standard medical protocol or are excluded in the plan (elective cosmetic surgery, for example). For an additional expense to the health fund, the City can seek qualified health care professionals in the different areas of medical specialty to review the third party administrator's determination. More than one area of medical specialty would be required in order for members to receive a "fair review". However, guidelines need to be established in order to determine what the process would be if the specialist employed by the City for a Level 2 appeal contradicts, the third party administrator's recommendation. Should the City seek a third opinion? The City also has to take into consideration that the charges incurred for any medical treatment contrary to the determination of the TPA's medical staff would not be subject to reimbursement from the stop loss carrier in the case of a large catastrophic claim.

The Third Party Administrator has other protocols for the appeal process. The City will work with the Third Party Administrator as well as the City's benefit consultant to review the current process, investigate how other self-funded plans handle the appeal process and develop an appeal process that will produce a "fair review' of the appeal.

Responsible Party

Irene Morales – OMB Insurance & Benefits Risk Manager and Monica Casarez – Benefits Supervisor

Implementation Date

A full review of the appeal process will begin immediately. A report to Deputy City Manager Bill Studer will be completed by February 1, 2010. If necessary, any changes to the appeal process within the City's Health Plan will be accomplished during the FY11 budget process.

Current Observation

Insurance and Benefits has implemented a process to ensure that employees are being provided with a fair review of appeal documentation. Aetna has added a new requirement for reviewing medical claims to the appeal process. The new requirement allows employees submitting a medical claim the option to file a *Voluntary Appeal* if their claim has been denied by the Third Party Administrator (Aetna) and/or the City of El Paso. A *Voluntary Appeal* provides an external review from an independent physician who has expertise in the problem or question involved in their claim. Aetna, the City of El Paso, and the Health Plan have agreed to abide to the decision made by the external reviewer.

Status

Implemented

Original Finding 3

Policies and Procedures

The current OMB Insurance and Benefits Policies and Procedures in place are a work in progress and have not been finalized.

- OMB Insurance & Benefits does not have vendor specific procedures to help identify what processes are used for each of the vendors it sends payments to.
- The procedures in practice for the administration of benefit files and workers' compensation files have not been documented.

Recommendation

OMB Insurance and Benefits Standard Operating Procedures Manual should be finalized and disseminated to all OMB Insurance and Benefits personnel as part of their on-going training.

Management's Response

Insurance & Benefits anticipates a change in some of the vendors effective January 1, 2010. Vendor specific procedures to help identify process for specific vendor payments will be drafted and included with the existing Policies and Procedures to be finalized by January 31, 2010. Included in these Policies and Procedures will be a procedure for safeguarding the benefit and worker's compensation files. The door to the file room has a combination lock; the combination is provided to the Insurance & Benefits staff only. The current procedure is to have the door to the file room closed and locked between 5:00 PM and 8:00 AM. The door is open between normal working hours and the area is accessible to Insurance & Benefits staff only. The door is closed during normal business hours if there is no staff in the office during this time; for example, during fire drills.

Responsible Party

Irene Morales – OMB Insurance & Benefits Risk Manager, Monica Casarez – Benefits Supervisor, Seone Jones – Senior Safety Specialist, Irene Herrera – Accountant, and Steve Burman – OMB Administrative Analyst

Implementation Date

January 31, 2010

Current Observation

The Insurance and Benefits Division has created and disseminated procedures to help identify what processes are used when vendor payments are sent. However, Insurance and Benefits has not documented their procedures for the administration of benefit files. It has been acknowledged by the Insurance and Benefits Division that a practice is in place for the administration of benefit files, but the procedures in practice have not been documented. Reasonable progress has been done to classify the finding as "Implemented" and management has been notified that procedures for the administration of benefit files need to be documented to fully implement this finding.

Status

Implemented

Original Finding 4

United Concordia Electronic Uploads

All "invoiced" retirees with United Concordia Dental Coverage were not being included in the data upload used to transmit member coverage information. However, subsequent to our initial review, the coding used for the data upload was corrected. The Internal Audit Office confirmed that the updated upload contained invoiced retirees.

Recommendation

OMB Insurance & Benefits should implement a review process of third party provider data uploads to ensure that uploads are complete and accurate.

Management's Response

The project to identify different errors in this particular vendor file began in March 2009. The on-site ancillary representative was entering new invoiced retirees and any changes in this group manually. In working with City IT staff, the invoiced retirees are now included in the interface file to Concordia so no further manual entries are required. The recommendation by the internal audit staff was completed in August 17, 2009. The on-site ancillary representative is responsible for reviewing the error reports sent by Concordia after the file is uploaded.

In the most recent ancillary benefits request for proposal, language was included that would require the successful vendors to exchange exception information with the City after any upload of information. The use of the on–site ancillary representative to handle the exception reports will be expanded to include all ancillary vendors.

Responsible Party

Irene Morales – OMB Insurance & Benefits Risk Manager, Monica Casarez – Benefits Supervisor, and Luis Martinez – Ancillary Benefits Account Manager

Implementation Date

January 2010

Current Observation

A review process has been put in place to ensure that uploads are complete and accurate.

A review of 10 invoiced retirees was conducted to determine if uploads to the United Concordia system are complete and accurate. Our results identified that:

- 10 out of 10 (100%) invoiced retirees were listed in the United Concordia upload.

Status

Implemented

Original Finding 5

Expenditures Review Process

Vendor invoices are not being adequately reviewed before payment. For the period of 9/1/2008 to 5/31/2009, eight Aetna invoices and forty Medco invoices were selected for review. The following exceptions were noted:

<table>
<tr><th>Vendor</th><th>Exceptions</th></tr>
<tr><td>Aetna</td><td>

Eight out of eight (100%) invoices listed fees that could not be confirmed.

An average variance of 400 employees was identified between Aetna's volume numbers and the volume numbers contained in the OMB Benefit Census Reports; with Aetna billing for more employees than was listed in the Census Reports.

<table>
<tr><th>Invoice Due Date</th><th>Originally Provided Benefit Census Reports</th><th>Aetna invoice</th><th>Variance</th><th>*Revised Benefit Census Report</th></tr>
<tr><td>September 08</td><td>5,075</td><td>5,570</td><td>495</td><td>5,080</td></tr>
<tr><td>March 09</td><td>5,300</td><td>5,703</td><td>403</td><td>5,220</td></tr>
<tr><td>June 09</td><td>4,897</td><td>5,210</td><td>313</td><td>5,269</td></tr>
</table>
*During the course of the audit, OMB Insurance & Benefits identified an error in the OMB Census Reports and made the necessary corrections. As of the September 2009 invoice, the variance between the Benefit Census Report and Aetna is down to a difference of 2 employees.

One of eight (13%) invoices did not have an invoice on file but was still paid.
Four of the eight (50%) invoices contained a billing rate that was not adequately supported until a request was submitted by the Internal Audit Office. The billing rate break-down provided by Aetna adequately supported the billing rate currently in use.

A review of the 20 payments made to Aetna for claims paid during the month of May 2009 was conducted. The daily claim payment amounts could not be reconciled to the monthly "Claims Detail Report" provided by Aetna.

</td></tr>
<tr><td>Medco</td><td>35 out of 40 (88%) vouchers listed additional fees that could not be confirmed.

35 vouchers contained "medicaid" fees in which the quantity billed could not be confirmed.
Three vouchers contained "client liability" amounts totaling $340.00 for unpaid member copays. Medco bills the City of El Paso for these "client liabilities" but does not provide information regarding these members. Therefore, OMB Insurance and Benefits pays the "client liability" and does not bill the corresponding "member" for the unpaid copay.

</td></tr>
</table>

Recommendation

OMB Insurance and Benefits should implement oversight procedures and a reconciliation process to ensure vendor fees and quantities are accurately billed. We are aware that reconciling every invoice would be burdensome; therefore we are not asking that it be conducted daily, but instead that the invoices be spot-checked for accuracy.

Management's Response

Insurance & Benefits staff began working on these discrepancies in the Aetna invoices in December 2008. Insurance & Benefits and IT staff started to identify programming discrepancies in the interface between the City of El Paso and Aetna. City staff also worked to identify any discrepancies in the monthly census query that is used in the comparison. In August 2009, the programming issues were resolved with both programs. An example of the City's census reports and the census on the Aetna invoice after the corrections were made follows:

EE Census Date	COEP EE Volume	EE Volume Aetna Billing	Difference
02/17/09	5220	5691	471
03/15/09	5232	5342	110
04/15/09	5243	5379	136
05/21/09	5269	5198	-71
06/30/09	5284	5210	-74
07/27/09	5236	5234	-2
08/31/09	5239	5237(run date 8/25/09)	-2

Insurance & Benefits staff changed its monthly reconciliation procedure of the Aetna invoices in August 2009. Insurance & Benefits staff was running the internal census query on or about the first of every month. The Aetna census reflected on the billing invoice is run on the 'prepared date" reflected on the invoice. The internal City census query will be run on the "prepared date" on the Aetna invoice in order to have a better comparison of the two census reports.

The monthly "Claims Detail report" contains all claims paid by Aetna on behalf of the City of El Paso Health benefit plan for any given month. The daily claim payment amounts processed by the City of El Paso to Aetna are the total amount of Aetna checks that have cleared the bank. The Aetna outstanding issues report contains a cumulative amount of Aetna checks that have not been processed for payment.

Management's Response (cont.)

The Medco Medicaid fees are for the Medicaid, Local/State Agencies Subrogation program. Subrogation occurs when a federal or state entity pays a claim for which it is not responsible and seeks to recover the cost of the claim from the primary payer. Legally, Medicaid and other government entities, except for Medicare are payers of last resort. When Medicaid or another government entity has paid a claim that is covered by another payer-in this instance, a Medco client (the City) - the client is obligated to reimburse the government for the claim. The City has elected to allow Medco to act as the administrator for these claims. This is a common service provided by pharmacy benefit managers for their clients. In speaking with Medco, they stated that if the City of El Paso wanted a detailed listing of the members for which they reimbursed Medicaid, they would begin to send the reports on a monthly basis. They also indicated that 1% or less of their clients request these reports. The "Medicaid Fees" for FY09 totaled 4% ($7,792.85) of the total paid to Medco in Administrative fees.

The "client liability" charge is for unpaid member copays that exceed 120 days. Medco bills on a quarterly basis. If the member subsequently remits payment on their own within the following quarter for an amount paid by the client and the account is in a credit status prior to billing, the system will automatically issue a credit to the clients admin invoice each quarter where applicable. The City, has requested monthly reports that would substantiate the "client liability" charges in the administrative fees. The "client liability" charges totaled .1% ($1,690) of the total paid to Medco in administration fees.

Responsible Party

Irene Morales – OMB Insurance & Benefits Risk Manager and Irene Herrera – Accountant

Implementation Date

Aetna census comparison – August 2009. Medco – September 2009

Current Observation

The Insurance and Benefits Division has set up oversight procedures to ensure proper payment of vendor invoices. Also, a reconciliation process has been put in place to ensure that proper quantities are being billed.

A sample of Aetna invoices were selected to determine if Aetna's volume number and Insurance and Benefits' Benefits Census Report were reconciling. Our testing identified that these two reports are still not reconciling. However, the variances between these two reports have been decreasing each month and are at immaterial levels. The chart below illustrates the variances identified in our sample:

Invoice Due Date	Aetna Invoice Volume #	Benefit Census Report Volume #	Variance
May 2011	5,240	5,287	47
June 2011	5,230	5,261	31
July 2011	5,236	5,281	45
August 2011	5,246	5,261	15

Current Observation (cont.)

A sample of 16 Medco invoices were selected for review to determine if vendor fees and quantities are being reviewed before payment.

- 15 out of 16 (94%) invoices reviewed listed additional fees that could not be confirmed by the Insurance and Benefits Division.
  - Three invoices listed different unit rates for Client Liability; $60.00, $105.00, and $210.00.
  - The quantity and fees billed for additional fees could not be supported or explained by the Accountant of Insurance and Benefits.
- Additional Fees totaled $2,158.20 out of $24,042.55 (9%) of the total invoices reviewed.
  - $243.00 consisted of "Medicaid" fees.
  - $480.00 consisted of "Client Liability" fees.
  - $1,435.20 consisted of "Retiree Drug Subsidy – Application" fees.

We have determined that the "Additional Fees" identified in our sample ($2,158.20) are deemed immaterial as to the total amount reviewed ($24,042.55).

Status

In Progress – Our review has identified improvement in addressing this finding. We have determined that unsupported charges continue to be included in the Medco billing. Although the dollar amount is immaterial to the overall Prescription Drug Program, the Insurance and Benefits Division needs to continue monitoring these unsupported charges. Attempts need to be made to identify employees involved and invoice them for these charges.

No further follow-up will be conducted on this finding. The management of the Insurance and Benefits Division will assume the residual risk of not fully implementing the agreed upon recommendation.

Original Finding 6

Health Fund and Workers Compensation Cash Flow Analysis

The "Cash at beginning of Period" amounts being used by OMB Insurance & Benefits for the two separate Cash Flow Analysis conducted of the Health Fund and the Workers' Compensation Fund are misrepresented by the title used.

- The balances identified are "fund" balances, also commonly referred to as net-assets, not cash balances as stated in the reports.
- The beginning balances used by OMB Insurance & Benefits do not correspond to the amounts listed in the City of El Paso Financial Statements:

Fund	OMB Cash Flow Analysis as of June 2009	Combined Statement of Revenue, Expense and Changes in Fund Net Assets for month ended June 30, 2009	Difference
Health Fund	<$13,111,751>	<$13,118,323>	<$6,572>
Workers Compensation	$8,513,325	$8,512,441	$884

However, subsequent to our review the "Cash at beginning of Period" amount was corrected to correspond to the City of El Paso Financial Statements but the use of the word "cash" was still utilized to refer to the analysis and balances.

Recommendation

The Health Fund and Workers' Compensation Cash Flow Analysis Reports should appropriately title listed balances as "fund balances" and use balances that correspond to the amounts listed in the City of El Paso Financial Statements.

Management's Response

The terminology "Cash at the Beginning of the Period" will be changed to "Fund Balance" with the cash flow statements beginning September 2009.

Responsible Party

Irene Morales – OMB Insurance & Benefits Risk Manager and Irene Herrera – Accountant

Implementation Date

September 2009

Current Observation

The Health Fund and Workers' Compensation Cash Flow Analysis Reports have been appropriately titled as "fund balances."

The beginning balances listed on these analysis reports do not correspond to the amounts listed in the City of El Paso Financial Statements. The variance is due to these analysis reports being prepared before the Financial Statements are published.

Status

Implemented

INHERENT LIMITATIONS

Because of the inherent limitations of internal controls, errors or irregularities may occur and not be detected. Also, projections of any evaluation of the internal control structure to future periods are subject to the risk that procedures may become inadequate due to changes in conditions, or that the degree of compliance with the procedures may deteriorate.

CONCLUSION

We have concluded our audit work on the objectives of the Follow-Up Audit – OMB - Insurance and Benefits. Based on the results of our review, we have determined that five (5) of the original findings have been implemented and one (1) is still in progress of being fully implemented.

Although the dollar amounts identified in the remaining finding are deemed immaterial, the management of the Insurance and Benefits Division needs to attempt to identify the employees with unpaid charges. These employees need to be invoiced for the unpaid charges, since the City of El Paso has paid these charges. Until this occurs, the management of the Insurance and Benefits Division will assume the residual risk of having these charges continue to go unpaid.

No further audit work will be conducted in this area at this time. The management of the Insurance and Benefits Division can expect future audit work to be conducted in this area.

We wish to thank the Insurance and Benefits Division's Management and Staff for their assistance and courtesies extended during the completion of this Follow-Up Audit.

Signature on File
Edmundo S. Calderón, CIA, CGAP, CRMA, MBA
Chief Internal Auditor

Signature on File
Miguel Ortega,
Auditor

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